



SOCIAL HISTORY FORM

NAME OF NURSING CARE FACILITY _____

NAME: _____ MEDICAID NO.: _____
LAST FIRST MIDDLE

LAST PERMANENT ADDRESS: _____
OWN HOME _____ RELATIVE _____ OTHER _____
NURSING HOME (Name) _____ (Identify) _____

MARITAL STATUS _____ DOES THE PATIENT OR HIS SPOUSE MAINTAIN A HOME? YES _____ NO _____

CULTURAL BACKGROUND (Home Situation) _____

FAMILY COMPOSITION:

NAME	ADDRESS	TELEPHONE NO.	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

OCCUPATION _____ WHEN LAST EMPLOYED _____ WHERE LAST EMPLOYED _____

ORGANIZATIONS: (1) _____ (2) _____ (3) _____

RELIGION _____ CHURCH AND LOCATION _____ ACTIVE _____ INACTIVE _____

INTERESTED PERSONS/GROUPS/AGENCIES:

NAME	ADDRESS	TELEPHONE NO.	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SPECIAL INTERESTS, ABILITIES, HOBBIES:

HANDICRAFTS _____ MUSIC _____ READING _____ TV _____ TRAVEL _____ OTHER _____

HABITS AND PREFERENCES _____

EVALUATION OF FAMILY/SIGNIFICANT PERSON _____

DISCHARGE PLANNING NAME	SIGNIFICANT PERSON(S)/AGENCY ADDRESS	TELEPHONE NO.	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PREPARED BY _____

TITLE _____

DATE _____